MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12310

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MARY	E.	ABBOTT	09 03 68	2:10 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	09-19-12	55 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
WEST VIRGINIA	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY COUNTY, Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	CLERK	DEPT. STORE

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	LONACONING	YES [X] NO [ ]	23 DOUGLAS AVENUE

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
David	E.	Park	Winifred		Guy

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	219-03-8164	SACRED HEART HOSPITAL-900SETON DR., CUMB.,MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease — 4 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 9/2, 19 68, to 9/3, 19 68, that (I) (we) last saw the deceased alive on 9/3, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
J. A. Pagan		[X]	[ ]	[ ]	9/4/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
J. A. PAGAN, M.D.	5 POTOMAC ST., RIDGELEY, W. VA. 26753

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/5/68	Laurel Hill Cemetery	Moscow A. Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
EICHHORN FUNERAL HOME-8 E. MAIN ST., LONACONING, MD.	SEP 6 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12311 12321

1

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
NICHOLAS	M.	ABEY	SEPTEMBER 8, 1968	6:15PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
MALE	WHITE	11-14-1888	79 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	USA	WIDOWED X	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Carmen Helper-Retired	B & O R R

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
W. VA.		RIDGELEY	YES X NO	41 BRIDGE ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOHN	H.	ABEY	MARY	MC KENZIE	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WW 1	232-20-6589	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobar pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(b) Pulmonary emphysema
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 492X

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
5271 chronic pulmonary hypertensive heart disease

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 8-30, 1968, to 9-8, 1968, that (I) (we) last saw the deceased alive on 9-8 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Vaiben P. Dross		X	☐	☐	9-9-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. V. DROSS	456 N. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/11/1968	Hillcrest Burial Park	Near Cumberland Alleg Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John J. Hafey, Jr	230 Balto Ave Cumberland Md	SEP 16 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (R)
30M REV. 2-68

1

12312

12322

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First: DEWEY	Middle: D.	Last: BARNES	2a. DATE OF DEATH Month: 09 Day: 02 Year: 68	2b. HOUR: 2:20 P.M.
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 11-07-99	6. AGE (In years last birthday) YRS.: 68	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY		Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED Laborer	12b. KIND OF BUSINESS OR INDUSTRY: RETIRED Paper Mill		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: BARTON	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: RT. 1.	
14. FATHER'S NAME First: Sheridan	Middle: ELWOOD	Last: BARNS	15. MOTHER'S MAIDEN NAME First: SARAH	Middle:	Last: DIEHL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service): 213-03-0803	17. INFORMANT: HOSPITAL RECORD-SHH-CUMBERLAND, MD.	Address		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchogenic Carcinoma. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

DUE TO, OR AS A CONSEQUENCE OF

(b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Generalized Arteriosclerosis.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Clarence J. Vincent	M.D.	☑	☐	☐	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. VINCENT - BMG	SETON DR., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	9/5/68	Potomac Valley Gardens	Keyser	Mineral	W. Va.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
BOALS, WESTERNPORT, MD. E. Boal	Westernport, Md.	SEP 9 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12313 — 12323

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: JOSEPH	Middle:	Last: BARRINGER	2a. DATE KNOWN OF DEATH ☐ ESTIMATED ☐ Month: 9-12	Day	Year: 68	2b. HOUR: 4:10 P M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: May 6, 1896	6. AGE (In years last birthday): 72 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.		2c. DATE PRONOUNCED DEAD Month: 9 Day: 12 Year: 1968	2d. HOUR: 4:10 P M
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.			
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): D.O.A.Memorial H.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Fireman	12b. KIND OF BUSINESS OR INDUSTRY: Railroad			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 915 Virginia Ave.		
14. FATHER'S NAME First: Joseph	Middle:	Last: Barringer	15. MOTHER'S MAIDEN NAME First: Susan	Middle:	Last: Rainer	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS: Claude Barringer, Cumberland, Md.-Son				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS — 11
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county): Rt.9, Cumberland
22b. DATE SIGNED: Sept.12, 1968

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept.15, 1968	Rose Hill Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	SEP 17 1968	Charles Judge

VR A15ME (5) 10M REV. 1/68

1

12314

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12321

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
OTTO	CLIFTON (C.)	BEAN	9 12 68	11 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	10/2/99	68 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
WEST VA.	UNITED STATES		ALLEGANY CO., Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSP.	CUSTODIAN -School	CUSTODIAN

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	320 BOND STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
EMORY		BEAN	MARY	(STARKEY)	STARKIE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	217 10 6400	PATIENT'S HOSPITAL CHART

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Mesenteric thrombosis, Massive	6 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)	ASHD c Atrial Fibrillation	unk.
DUE TO, OR AS A CONSEQUENCE OF (c)	Generalized Steatorrhea's	unk.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4129

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

4200 Pulmonary Emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 8/14, 1968, to 9/12, 1968, that (I) (we) last saw the deceased alive on 9/12 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
J.A. Pagan		[X]	[ ]	[ ]	9/16/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. J. A. PAGAN	1068 NATIONAL HIGHWAY, LA VALE, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 15, 1968	St. Luke's Cemetery	Cumberland, Md. Allegany

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.		SEP 18 1968	Charles Judge

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12315 — 12325

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1. DECEASED NAME (Type or print)	First: Benson	Middle: Hill	Last: Bell	2a. DATE OF DEATH: Month Sept. Day 23, Year 68	2b. HOUR: 4:55 P.M.		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Oct. 1, 1879	6. AGE (In years last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): Georgia	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md				
10. CITY OR TOWN OF DEATH: Cumberland,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Ret. Tax Collector	12b. KIND OF BUSINESS OR INDUSTRY: County Gov't				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Penna.	13b. COUNTY: Bedford,	13c. CITY OR TOWN: Rt. # 2 Cumberland, Md.	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: Pine Ridge Road			
14. FATHER'S NAME: First Benson	Middle A.	Last Bell	15. MOTHER'S MAIDEN NAME: First Fannie	Middle --	Last Hargrove		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No,	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 254-50-7476	17. INFORMANT: Mrs. Russell G. Eversole	Address: Cumberland, Md. Rt. # 2 Box 692,			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive heart failure — Approximate interval between onset and death: 1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary insufficiency — 8 days

DUE TO, OR AS A CONSEQUENCE OF (c): Rt pneumothorax — 10 days

4199

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

.171 Pulmonary emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 9-13, 19 68, to 9-23, 19 68, that (I) (we) last saw the deceased alive on 9-23 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Vasilios P. Dross MD	DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: Sept. 24, 1968	
22d. PHYSICIAN'S NAME (Type): Vasilios P. Dross, M. D.	22e. ADDRESS: 456 N. Centre St. Cumberland, Md. 21502		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 9/27/68	23c. NAME OF CEMETERY OR CREMATORY: West View Cemetery,	23d. LOCATION (City or Town) (County) (State): Atlanta, Fulton, Georgia	
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: Cumberland, Maryland	25a. REC'D BY REGISTRAR DATE: SEP 26 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12316

CERTIFICATE OF DEATH

Item#13c e FilmG 05 10/18/68 km

12326

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Douglas	R.	Bowie	Sept	12	68	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Male	White	May 6, 1902	66 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARITAL STATUS	9. COUNTY OF DEATH
Cumberland Md	U. S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland Md.	210 Forest Drive	Retired Fiber Co Proc.	Paper

13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md	Allegany	Cumb. Md.	YES [X] NO [ ]	210 Forest Drive

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Robert	E. Lee	Bowie	Charlotte		Wilson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No			Mrs. Douglas Bowie	Cumb. Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 4-25-, 19 68, to 9-12-, 19 68, that (I) ~~(we)~~ last saw the deceased alive on 8-26- 19 68, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Wm. F. Williams		[X]	[ ]	[ ]	9-14-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
	122 S. Centre St. Cumberland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/19/68	Rose Hill Cem.	Cumberland Allegany Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Louis Stein Inc.	Cumb. Md.	SEP 16 1968	J. Charles Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon sheets. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A 15 (1)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12317

CERTIFICATE OF DEATH

12327

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
ROSE	A.	BRAILER	9	21	68	3:45 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
FEMALE	WHITE	10-15-95	72 YRS				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
MARYLAND	USA		ALLEGANY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	HOUSEWIFE	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	MT. SAVAGE	YES ☒ NO ☐	MT. SAVAGE, MARYLAND

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
AUGUSTINE		BRAILER	MARY	PENDLEBERRY	BRAILER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, (Unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT	Address
NO	216 22 7071	SACRED HEART HOSPITAL	900 SETON DRIVE CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	congestive heart failure	2 wks
DUE TO, OR AS A CONSEQUENCE OF (b)	hypertensive heart heart disease	20 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)	intestinal obstruction	2 wks.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4120 4422 X

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
diabetes mellitus-generalized visceral failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
9-18-68	intestinal obstruction	YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
		none

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	none				

22a. I **certify** that (I) (this hospital) attended the deceased from 4-23-50, 19__, to 9-21-68, 19__, that (I) (we) last saw the deceased alive on Sept. 21, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 3:45 PM

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c DATE SIGNED
James P. Hallinan M.D.					9-23-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. JAMES P. HALLINAN	140 BEDFORD ST -CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	9-24-68	ST. PATRICK'S CEMETERY	MT. SAVAGE, ALLEGANY, MD.

24 FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD.	SEP 26 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the undertaker, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
30M REV 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Items 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death

12318

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12328

1. DECEASED NAME (Type or Print) First: Floyd	Middle: Lloyd	Last: Carder	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month Day Year: Sept. 16, 1968	2b. HOUR: 6 a M			
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: July 2?, 1893	6. AGE (In years last birthday): 75 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month Day Year 19: Sept. 16, 1968	2d. HOUR: 6 aM
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. to give street address): Memorial Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Pipefitter-Railroad	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Oldtown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last: Silas P. Carder	15. MOTHER'S MAIDEN NAME First Middle Last: Rose A. Deffenbaugh						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS: Donald L. Carder, Oldtown, Md.-Son					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): GANGRENE OF BOWEL — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 16 Hours

DUE TO, OR AS A CONSEQUENCE OF

(b): MESENTERIC THROMBOSIS — 11

DUE TO, OR AS A CONSEQUENCE OF

(c): ARTERIOSCLEROSIS — ----

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — 14.2

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4500

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒☒ and in my opinion death resulted from. Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: September 16, 1968

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 18, 1968	Oldtown Cemetery	Oldtown, Md. Allegany

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	SEP 17 1968	J. Charles Judge

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12319

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12329

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death

1 DECEASED NAME (Type or Print) First: Charles	Middle: Walter	Last: Carroll	2a DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year: Sept. 10, 68	2b HOUR: 5 a.m.			
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: July 14, 1906	6 AGE (In years last birthday) 62 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month Day Year: September 10, 1968	2d HOUR: 7 a.m.		
7a. BIRTHPLACE (State or foreign country): Allegany	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: Allegany Md				
10 CITY OR TOWN OF DEATH: Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 310 Harrison St.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): None	12b KIND OF BUSINESS OR INDUSTRY: None				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b COUNTY: Allegany	13c CITY OR TOWN: Cumberland	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER: 310 Harrison St.			
14 FATHER'S NAME First / Middle / Last: John J. Carroll	15 MOTHER'S MAIDEN NAME First / Middle / Last: Anna Jane Walker						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT ADDRESS: Mrs. Cecil Colbert, Cumberland, Md.-Sister					

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Pulmonary Embolism, massive — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Varicosities of Lower Extremities — --

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES [X] NO [ ]
21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b DATE SIGNED: September 10, 1968

ADDRESS (Street, city, town, or county): Cumberland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: Sept. 21, 1968	23c NAME OF CEMETERY OR CREMATORY: St. Patrick's Cemetery	23d LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR / ADDRESS: James F. Scarpelli, Cumberland, Md.	25a. RECD BY REGISTRAR DATE: SEP 20 1968	25b. REGISTRAR'S SIGNATURE: Charles Judge		

VR ATSME (5)
10M REV. 1/68

no

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12320

CERTIFICATE OF DEATH

123.50

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
Tinnie	E.	Clise	9th. 4th. 1968	M

3. SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
Female	White	10/15/1898	69 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Garrett	USA.		Allegany Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Midland		House Wife	Home

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MD.	Allegany	Midland	YES ☐ NO ☐	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Andrew		Beeman	Mary		Green

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown	If yes give war or dates of service	16b. SOCIAL SECURITY NO.	17 INFORMANT	Address
NO			Mrs. Helen Blubaugh (Daughter)	Midland, Md.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Acute Coronary Occlusion — Approximate interval between onset and death: immediate

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease — years

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Advanced Arteriosclerosis — years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a I **certify** that (I) (this hospital) attended the deceased from _____, 19 56, to Sept. 4, 1968, that (I) (we) last saw the deceased alive on Sept. 1 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE	MD DEGREE	ATTENDING PHYS ☒	MED. DIRECTOR ☐	STAFF PHYS ☐	22c DATE SIGNED
L.R. Miles					9.5.68

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
L.R. MILES, JR., M.D.	LONACONING, MD. 21539

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/6/1968	Frostburg Memorial Park	Frostburg, Md.

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	SEP 6 1968	J. Charles Judge

VR A15 (4) 30M REV 1-68

12321

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

It m^3b, FilmG404 9/20/68 km

12321

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A(14) 30M REV 1/68

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Esther	I	Davis	Sept.	12	1968	M

3. SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Female	White	9/26/1906	61 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MD.	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Allegany Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Frostburg	Miners Hospital	House Wife	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MD.	Allegany	Lonaconing	YES [X] NO [ ]	Charlestown, ST.

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
John		Hendra	Janet		Hausman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No		Nelson Davis (Husband) Lonaconing, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Posterior Coronary occluston — (APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 hrs -)
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) H C V D - 3 yrs —
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State
		Today 2 hrs

22a. **I certify** that (I) (this hospital) attended the deceased from Year —, 19 4, to 9/12, 19 68 — that (I) (we) last saw the deceased alive on 9/12 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John B. Davis		[X]	[ ]	[ ]	9/12/68

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
John B. DAVIS, M.D.	Frostburg Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Sept. 16, 1968	Oak Hill Cemetery	Lonaconing, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn, Lonaconing, Md.	SEP 16 1968	Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death any delay s necessary, please execute the certificate, writing the word "pending" in parenth in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

12322

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12322

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) First	Middle	Last
Harry	Martin	Dicken

2a DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month Day Year: Sept. 11, 1968 — 2b HOUR: 5:20 AM

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Male	White	6-20-82	86 YRS		

2c DATE PRONOUNCED DEAD Month Day Year: September 11, 1968 — 2d HOUR: 7:10 AM

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. COUNTY OF DEATH
Penna.	USA		Allegany Md

10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	Retired Farmer	Farming

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	Allegany	Cumberland	YES [ ] NO [X]	Route 3, Valley Road

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Martin	L.	Dicken	Malinda		Gurley

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
No	213-24-5283	Homer Dicken	Route #3 Cumberland, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ACUTE HEMORRHAGIC PANCREATITIS	24 Hours
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	(Primary)	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
5870

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES [X] NO [ ]

21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M. D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MED. CA. EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b DATE SIGNED: September 11, 1968

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9-13-68	Centenary Cemetery	RT. 3 Cumberland Allegany Md.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
H. Lee Silcox	404 Decatur St., Cumb., Md.	SEP 13 1968	J. Charles Judge

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12323 12333

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Joseph (John)	J.	Dorn	9	19	68	3:45PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	White	April 9, 1900	68 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Allegany Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	(319 Caroline St.) 330 Byrd Ave.	Retired Fireman	Textile

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES ☒ NO ☐	(319 Caroline Street) 330 Byrd Ave.

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
George Dorn	Matilda Britton

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no			Mrs. Grace Dorn, Cumberland, Md. - Wife

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	MYOCARDIAL INFARCTION	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b)	4109	
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4101

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
			k

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from July, 19 68, to 9-19, 19 68, that ~~(I)~~ (we) last saw the deceased alive on 9-15 19 68, and that in ~~(my)~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~(I)~~ (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
L. Michael Glick M.D.		☒	☐	☐	9-20-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L. MICHAEL GLICK	BROADDUS MED GROUP CUMBERLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 23, 1968	St. Peter & Paul Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	SEP 24 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12324

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
Elizabeth	Mackey	Durst	September 30 1968	8:15A M

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
Female	White	June 21, 1891	77 YRS		

7a. BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
Maryland	U S A		Allegany Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Near Cumberland	Baltimore Pike	Housewife	---

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Allegany	Cumberland	YES ☒ NO ☐	304 Cumberland Street

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	George		Mary		Stevenson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT Address
No	214-05-4322	Mrs. Robert Altstetter, Balto Pike, Cumberlar Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Heart Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 years
4 1 0 7
DUE TO, OR AS A CONSEQUENCE OF (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4 1 Diabetes mellitus

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 6 - 1, 19 55, to 9-30, 19 68, that (I) (we) last saw the deceased alive on 9 - 29 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) ~~(did not)~~ view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Ralph W. Ballin M.D.	M.D.	☒	☐	☐	9-30-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Ralph W. Ballin, M.D.	62 Greene St., Cumberland, Md.

23a BURIAL, CREMATION REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	10/ 2/1968	Hillcrest Burial Park	Near Cumberland Alleg Md

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Charles E. Lafer, 230 Balto Ave. Cumberland	OCT 1 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(A) 30M REV. 6-68

12325

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12335

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Piercy	V.	Durst	Sept. 21 1968	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.
M	W	June 21, 1894	74 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Md.	USA		Allegany Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Miners. Hosp.	Farmer	Own Farm

13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Garrett	Frostburg	YES ☐ NO ☒	R.D.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Wesley		Durst	Sarah		Layman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	220-38-0203	Charles Durst, Star Rt., Frostburg, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Acute Brain Syndrome
DUE TO, OR AS A CONSEQUENCE OF
(b) Circulatory Disturbance
DUE TO, OR AS A CONSEQUENCE OF
(c) Hypertensive Vascular Disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 hrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
444X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
9/20/68	Ventral Hernia	YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this haspital) attended the deceased from Sept. 14 1968, to Sept. 21, 1968, that (I) (we) last saw the deceased alive an Sept. 20 1968, and that in (my) (aur) opinion death occurred an the date and haur and from the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
G. Paige Strong	ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	9/21/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/24/68	Mt. Zion Cemetery	Frostburg Allegany, Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Ruch Neuman	Grantsville, Md.	SEP 27 1968	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12326 12336

1. DECEASED-NAME (Type or print): First MARGARET Middle C Last EMERICK
2a. DATE OF DEATH: Month 9 Day 24 Year 68
2b. HOUR: 10:25 A.M.
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: 6-26-91
6. AGE (In years last birthday): 77 YRS
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.
7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Celanese employee
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 617 MONTGOMERY AVENUE
14. FATHER'S NAME: First JOSEPH Middle Last KREIGLINE
15. MOTHER'S MAIDEN NAME: First SARAH Middle A Last KENNELL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO: 214-07-1993
17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hypertension and Arteriosclerotic — Approximate interval between onset and death: 3 yrs
DUE TO, OR AS A CONSEQUENCE OF: Cardiac vascular disease
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) Large carcinoma of right ovary 6 mo

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4 yrs

19a. DATE OF OPERATION: 9-17-68
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma R ovary
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 9-12, 1968, to 9-24, 1968, that (I) (we) last saw the deceased alive on 9-23 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] M.D. DEGREE — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 9-25-68
22d. PHYSICIAN'S NAME (Type): DR. DONALD B. GROVE
22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: Sept. 27, 1968
23c. NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery
23d. LOCATION (City or Town) (County) (State): Hyndman, Bedford Co., Pa.
24. FUNERAL DIRECTOR: [signature] Address: Hyndman, Penna.
25a. REC'D BY REGISTRAR DATE: SEP 27 1968
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4) 30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12327 12337

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Martha	N.	Finley	September	10	68	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
Female	White	11/24/1891	78 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Miners Hospital	House Work	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md	Allegany	Lonaconing	YES ☐ NO ☒	West Main Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Albert		Crowe	Isabelle		Dunn

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
no			Ernest Finley "Husband"	Lonaconing, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute Coronary Occlusion	immediate
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Insufficiency	years
DUE TO, OR AS A CONSEQUENCE OF (c)	Generalized Arteriosclerosis	year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

41-1

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

401

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19 64, to Sept. 10, 19 68, that (I) (we) last saw the deceased alive on Sept 10 19 68 and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
L. R. Miles	ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	9-11-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L. R. MILES, JR., M.D.	LONACONING MD 21539

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/12/68	Frostburg Memorial Park	Frostburg A. Md

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	SEP 16 1968	Charles Judge

VII A 15 (H)
30M REV. 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

12328

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12328

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JANETTE	T.	GEORGE	09 13 68	12:20 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
FEMALE	WHITE	12-30-93	74 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY COUNTY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	HOUSEWIFE	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	Allegany	LONACONING	YES [ ] NO [X]	LONACONING, MD. STATE ROUTE 36 NORTH,

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ROBERT		RUSSELL	(TENNETT) JANETTE		RUSSELL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	213-01-6074	SACRED HEART HOSPITAL, CUMBERLAND, MD.	900 SETON DR. 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute coronary occlusion	12 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary sclerosis	1 year
DUE TO, OR AS A CONSEQUENCE OF (c)	arteriosclerosis	4 years

I 10.9 — Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 9-1-, 1968, to 9-12-, 1968, that (I) (we) last saw the deceased alive on 9-12- 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [ ]	22c. DATE SIGNED
L. Brings			9-14-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L. BRINGS, M.D.	57 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/15/1968	Memorial Park	Frostburg, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
LONACONING, MD. EICHHORN FUNERAL SERVICE,	8 E. MAIN ST.,	SEP 16 1968	Charles Judge

VR A15 (4) 30M REV 68

1

12329

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12339

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED-NAME (Type or print) First / Middle / Last	DELORES L. GRABENSTEIN	2a. DATE OF DEATH Month / Day / Year	9 17 68
2b. HOUR	4:15 PM		
3. SEX	FEMALE	4. RACE	WHITE
5. DATE OF BIRTH	4 22 89	6. AGE (In years last birthday)	79 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	MD.	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. COUNTY OF DEATH	ALLEGANY Md
10. CITY OR TOWN OF DEATH	CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	SACRED HEART HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	MARYLAND	13b. COUNTY	ALLEGANY
13c. CITY OR TOWN	CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	
13e. STREET AND NUMBER	BOX 363 -WINCHESTER ROAD		
14. FATHER'S NAME First / Middle / Last	HENRY METZNER	15. MOTHER'S MAIDEN NAME First / Middle / Last	ELIZA MOODY GRABENSTEIN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	NO	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	220-34-1301
17. INFORMANT	SACRED HEART HOSPITAL	Address	900 SETON DRIVE CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		Approximate interval between onset and death
IMMEDIATE CAUSE (a)	MYOCARDIAL FAILURE	5 MO.
DUE TO, OR AS A CONSEQUENCE OF (b)	ARTERIOSCLEROTIC HEART DISEASE	3 YRS.
DUE TO, OR AS A CONSEQUENCE OF (c)	CEREBRAL ARTERIOSCLEROSIS WITH CATATONIA	4 MO.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4/29 72(20)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

UREMIA-GENERALIZED VISCERAL FAILURE-SENILITY

19a. DATE OF OPERATION	NONE	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES ☐ NO ☒ #		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	NONE
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	NONE		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐		21e. PLACE OF INJURY (AT HOME, FARM STREET FACTORY, OFFICE BUILDING ETC.)	NONE
21f. LOCATION Street or R.F.D. No. / City or Town / County / State			

22a. I **certify** that (I) (this hospital) attended the deceased from SEPT. 18, 1961 to SEPT. 17, 68, that (I) (we) last saw the deceased alive on SEPT. 17, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. 415 PM

22b. SIGNATURE: James P. Hallinan MD — DEGREE: ATTENDING PHYS. # ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 9-18-68

22d. PHYSICIAN'S NAME (Type): DR. JAMES P. HALLINAN — 22e. ADDRESS: 140 BEDFORD ST. -CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
BURIAL	9/20/68	ST. MICHAEL'S CEMETERY	FROSTBURG, ALLEGANY, MD.	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
ARLOU M. SOWERS, Arlou M. Sowers	HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG	SEP 23 1968	Charles Judge	

VR A15(47) 30M REV 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12330

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12340

1. DECEASED-NAME (Type or Print)	First: Amanda	Middle: Emma	Last: Grenoble	2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐	Month: 9	Day: 21	Year: 68	HOUR: 11:05	A.M. ☐ P.M. ☒
3 SEX: Female	4 RACE: White	5 DATE OF BIRTH: March 11, 1887	6 AGE (In years last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD: Month Sept. Day 21 Year 1968	HOUR: 11:05	A.M. ☐ P.M. ☒			
7a BIRTHPLACE (State or foreign country): Cumberland,	7b CITIZEN OF WHAT COUNTRY?: U. S. A.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 COUNTY OF DEATH: Allegany Md								
10 CITY OR TOWN OF DEATH: Cumberland,	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hosp.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if ret red.): Ret. Press Feeder	12b KIND OF BUSINESS OR INDUSTRY: Printing								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admiss on) STATE: Maryland	13b COUNTY: Allegany	13c CITY OR TOWN: Cumberland,	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 210 Maryland Ave.							
14. FATHER'S NAME First: Ulrich	Middle: --	Last: Wiebel	15 MOTHER'S MAIDEN NAME First: Bertha	Middle: C.	Last: Lehman						
16a. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown): No,	(If yes give war or dates of service)	16b SOCIAL SECURITY NO: 214-05-4105	17 INFORMANT: Mr. Frank L. Wiebel	ADDRESS: 718 Oldtown Rd. Cumb. Md.							

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	45 minutes
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Thrombosis	45 Minutes
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Solerosis	----

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R F D No / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: September 21, 1968

ADDRESS (Street, city, town or county): CUMBERLAND, MARYLAND

23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	9/25/68	Rose Hill Mausoleum	Cumberland, Allegany Md.

24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Wayne George	Cumberland, Maryland	SEP 26 1968	J Charles Judge

VR A15ME (5) 10M REV 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 (Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12331

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12331

1. DECEASED NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN [X] OF ESTIMATED [ ] Month Day Year	2b. HOUR
Mary	Frances	Guy	Sept. 29, 1968	8:30 AM

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Female	White	March 8, 1919	49 YRS			September 29, 1968	PM 8:30 AM

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Westernport	130 Church St.		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Westernport	YES [X] NO [ ]	130 Church St.

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
James	A.	Walsh Jr.	Nora		Ryan

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO			Ethel Ann Guy	130 Church St.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Multiple Gunshots — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) (Homicide)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

N/A

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that I took charge of the remains described above, held an Autopsy [X] Inspection [X] Inquiry [X] and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [X], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: September 29, 1968

ADDRESS (Street, city, town, or county): Cumberland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 2, 1968	St. Peter's	Westernport Allegany Md

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Wm. H. Fredlock	Jones St.	OCT 7 1968	J. Charles Judge

VR A15ME (5) 10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12332

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12312

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED	Month	Day	Year	2b HOUR
Ralph	R.	Guy	X	Sept.	29,	1968	3:30 a M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	May 2, 1918	50 YRS			September 29, 1968	3:30 p M
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH				
Maryland	U.S.A.		Allegany Md				
10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY				
Westernport	130 Church St.	Clerk	Hardware				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER			
Md.	Allegany	Westernport	YES X NO ☐	130 Church St.			
14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last		
John		Guy	Ethel		Baggs		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS			
Yes	WW II	220-10-1319	Ethel Ann Guy	130 Church St.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Gunshot of Head — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF (b) (Suicide)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
—		YES X NO ☐

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No	City or Town	County	State

22a **I certify** that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry XX and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide X, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.
EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X
22b DATE SIGNED Sept. 29, 1968
ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Oct. 2, 1968	St. Peter's	Westernport Allegany Md.

24. FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REG STRAR DATE	25b REG STRAR'S SIGNATURE
Fredlock	Jones St. Piedmont, W.Va	OCT 7 1968	J. Charles Judge

VR A15ME (5)
10M REV 1/68

1

12333 Item 13 Film G405 10x26 #6 12312

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED-NAME (Type or print)	First: PEARL	Middle:	Last: HAY	2a. DATE OF DEATH Month: 9	Day: 23	Year: 68	2b. HOUR: 12:10
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 3-21-86	6. AGE (In years last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: ALLE GANY Md.				
10. CITY OR TOWN OF DEATH: CUMBERLAND,	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: MD. Pa.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: Meyersdale CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: RD 1 CUMBERLAND NURSING HOME			
14. FATHER'S NAME First: NORMAN	Middle: D	Last: HAY	15. MOTHER'S MAIDEN NAME First: AGNES	Middle:	Last: GLOTEELTY		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Arteriosclerotic heart disease, ~~Generalized~~ ~~arteriosclerosis~~ — Approximate interval between onset and death: 4 years

DUE TO, OR AS A CONSEQUENCE OF (b): Generalized arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Old Cerebrovascular accident, Mild Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 16 Aug, 1968, to 23 Sept, 1968, that (I) (we) last saw the deceased alive on 23 Sept 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22c. DATE SIGNED
Andrew Stasko MD					9-27-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. W. A. VAN ORMER	CUMBERLAND, MD.

23a. BURIAL-CREMATION-REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	SEPT 27, 1968	ST PAUL CEMETERY	MEYERSDALE 101 Somerset Pa

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
PRICE FUNERAL HOME M. R. Leatherby	325 MAIN ST MEYERSDALE, Pa	SEP 30 1968	J. Charles Judge

VR A15 (4) 30M REV. 1/68

1

12334

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12311

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
CLARA	A.	HECK	09	20	68	10A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
FEMALE	WHITE	03-16-08	60 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARITAL STATUS	9. COUNTY OF DEATH
MARYLAND	USA	MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address or location)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	HOUSEWIFE	NONE

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	OLDTOWN	YES ☒ NO ☐	ROUTE 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
DANIEL	WILLIAM	LEASURE	RUTH	WILMA	PIPER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	NONE	HOSP., RECORD 900 SETON DR., CUMB., MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Stroke — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerosis — 5 years

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

334 X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 9-11-, 1968, to 9-20-, 1968; that (I) (we) last saw the deceased alive on 9-19-, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
L. Brings	ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	9-20-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. L. BRINGS	57 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	9/23/1968	Davis Memorial Park	Near Cumberland	Alleg	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HAFER'S Charles E. Hafer	BALTIMORE AVE., CUMB., MD.	SEP 24 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12335

CERTIFICATE OF DEATH

12315

1 DECEASED NAME (Type or print): First HOMER; Middle S.; Last HIGGINS

2a. DATE OF DEATH: Month 09 Day 20 Year 68

2b. HOUR: 1:22 P M

3. SEX: MALE

4. RACE: WHITE

5. DATE OF BIRTH: 06-13-08

6. AGE (In years last birthday): 60 YRS

IF UNDER 1 YEAR: MONTHS; DAYS

IF UNDER 24 HRS: HOURS; MIN.

7a. BIRTHPLACE (State or foreign country): MARYLAND

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. COUNTY OF DEATH: ALLEGANY Md

10. CITY OR TOWN OF DEATH: CUMBERLAND

11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL

12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): SUPERVISOR

12b. KIND OF BUSINESS OR INDUSTRY: PUBLIC SCHOOLS

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND

13b. COUNTY: ALLEGANY

13c. CITY OR TOWN: LA VALE

13d. INSIDE CITY LIMITS? YES [X] NO [ ]

13e. STREET AND NUMBER: 1264 VOCKE RD.

14. FATHER'S NAME: First PATRICK; Middle; Last HIGGINS

15. MOTHER'S MAIDEN NAME: First ELLA; Middle; Last SCOTT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes give war or dates of service): W.W. 2

16b. SOCIAL SECURITY NO.: 220-16-6974

17. INFORMANT: HOSP., RECORD; Address: 900 SETON DR., CUMB., MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CVA

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): HASCVD

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

HTN

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [X]

20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 9-20 — 1968 and that in (my) (our) opinion death occurred on the date and hour and from the couses stoted above, (I) (we) (did) (did not) view the body ofter death.

22b. SIGNATURE: Dr. Matthew L Kaufman DEGREE: MD — ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]

22c. DATE SIGNED: 9-20-68

22d. PHYSICIAN'S NAME (Type): DR. MATTHEW L. KAUFMAN

22e. ADDRESS: 912 SETON DR., CUMB., MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: 9-23-1968

23c. NAME OF CEMETERY OR CREMATORY: HILLCREST BURIAL PARK

23d. LOCATION (City or Town) (County) (State): CUMBERLAND ALLEG. MD.

24. FUNERAL DIRECTOR: DURST FUNERAL HOME

ADDRESS: FROSTBURG, MD.

25a. REC'D BY REGISTRAR DATE: SEP 25 1968

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15-4
30M REV-1-68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12336 12316

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
LUCY	E.	HOLCOMB	SEPTEMBER 11, 1968	4:12 P.M.

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
FEMALE	WHITE	10-3-95	72 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
W.VA.	U. S. A.	WIDOWED X	ALLEGANY Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	HOUSE WIFE	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS? YES / NO	13e STREET AND NUMBER
PENNA.	BEDFORD	BEDFORD	NO X	RT. 3

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
JAMES	W.	JORDAN	FANNIE	S.	SHOVER

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
No	201-32-7973	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 yr
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of cervix — 2 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1 I X
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Obesity

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO X	

21a. ACCIDENT WAS UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d INJURY OCCURRED While at work / Not while at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from ____, 19 Feb. to Sept 11, 1968, that (I) (we) last saw the deceased alive on Sept 11 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
DR Grove MD	ATTENDING PHYS X / MED. DIRECTOR / STAFF PHYS	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. DONALD B. GROVE	122 S. CENTRE ST., CUMB. MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	9/14/68	Hillcrest Burial Park	Cumberland Allegany Maryland

24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. Lee Silcox	Cumberland, Maryland 21502	SEP 16 1968	Edward Yonga

VR A15 (4-68) 30M REV 1-68

12337

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12347

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ORVEL	R.	HOWELL	SEPTEMBER 2, 1968	2:10 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
MALE	WHITE	FEBRUARY 8, 1892	76 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
BARTON, MD.	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Pipefitter	Plumbing

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND,	YES [X] NO [ ]	608 E. FIRST ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JEFFERSON	R.	HOWELL	Harriett (HATTIE)	E.	MOORE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
Yes	W.W.I	214-07-6973A	MEMORIAL HOSPITAL,	CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Accident Carpenter's Leave

DUE TO, OR AS A CONSEQUENCE OF (b) Burning arm Shoulder

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

1510

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

151 X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
			Cumberland	Allegany	Md

22a. I certify that (I) (this hospital) attended the deceased from Aug 21, 19____, to 9-2-68, 19____, that (I) (we) last saw the deceased alive on 9-1-68 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS [X]	MED DIRECTOR [ ]	STAFF PHYS [ ]	22c. DATE SIGNED
					9/4/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. R.J. WILLIAMS	122 SO. CENTRE STREET, CUMB., MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 4, 1968	Davis Memorial Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Philip B. Wendt Memorial Ave., Cumb., Md.	SEP 5 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (4) 30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12338

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12119

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

1 DECEASED NAME (Type or Print) First: Clarence	Middle: Edward	Last: Jackson				2a DATE OF DEATH KNOWN [X] ESTIMATED [ ]: Month Day Year 9-26-68	2b HOUR 4:55 P M	
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: Nov. 1, 1895	6 AGE (In years last birthday): 72 YRS	IF UNDER 1 YEAR: MONTHS 10 DAYS 25	IF UNDER 24 HRS: HOURS MIN	2c DATE PRONOUNCED DEAD: Month September Day 26, 1968 Year 19	2d HOUR 4:55 P M	
7a BIRTHPLACE (State or foreign country): New Creek, W.Va. U.S.A.	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: Allegany Md.					
10 CITY OR TOWN OF DEATH: Cumberland, Md.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital-DOA	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired Carpenter	12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE: Md.	13b COUNTY: Allegany	13c CITY OR TOWN: Rawlings	13d INSIDE CITY LIMITS? YES [ ] NO [X]	13e STREET AND NUMBER: Rawlings Heights				
14 FATHER'S NAME First Middle Last: Charles Edawrd Jackson	15. MOTHER'S MAIDEN NAME First Middle Last: Katherine Louise Ashby							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes	(If yes give war or dates of service): WW1 Army	16b SOCIAL SECURITY NO: 216-09-8531	17 INFORMANT: Mrs. Elma Jackson (Wife)	ADDRESS: Rawlings, Md.				

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b): CORONARY SCLEROSIS — --

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last. 4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

421

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES [ ] NO [X]
21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State	

22a **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic MD

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b DATE SIGNED: September 26, 1968

ADDRESS (Street, city, town or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	9-29-68	Ebenezer Cemetery	Near Romney, W.Va.

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Harald W. McKenzie	Keyser, W.Va.	SEP 30 1968	J. Charles Judge

VR A15ME (5)
10M REV 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12339 — 12349

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
LEMUEL	G.	KIRK	9	25	68	8:40 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN
MALE	WHITE	9-25-1880	88 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PA.	U. S. A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSP.	Retired Contractor	State Roads

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	1825 FREDERICK ST.,

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
LEMUEL		KIRK	ALICE		CHESTNUT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no			MEMORIAL HOSPITAL-CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Sudden Cardiac arrest	25 Sept. 68
DUE TO, OR AS A CONSEQUENCE OF (b)	Congestive Heart failure	3 weeks
DUE TO, OR AS A CONSEQUENCE OF (c)	Myocardial Infarction, Intercepted	16 aug. 68

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): A.S. Cardiovasc disease 5 years

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from Jan., 19 68, to 25 Sept., 19 68, that (I) (~~we~~) last saw the deceased alive on 22 Sept. 19 68, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
W. A. Van Ormer, M.D		[X]	[ ]	[ ]	29 Sept. 68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. W. A. VAN ORMER	122 S. CENTRE ST., CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 28, 1968	Presbyterian Cemetery	Warfordsburg, Pa.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	OCT 3 1968	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12340

CERTIFICATE OF DEATH

12350

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
WILLIAM	B.	KISER	SEPTEMBER 2, 1968	1:17 A M

3. SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
MALE	WHITE	Nov. 5, 1915	52 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
KEYSER, W.VA.	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND, MD.	MEMORIAL HOSPITAL, CUMB., MD.	Brakeman	B+O RR

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND,	YES [ ] NO [ ]	496 WILLIAMS STREET

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
CHARLES	E.	KISER	MAUDE		BLAIR

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
No		MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Carcinoma of the Liver, Ascites, Pancreatitis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Unknown

DUE TO OR AS A CONSEQUENCE OF Jaundice — over 2 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) _____

DUE TO, OR AS A CONSEQUENCE OF

(c) _____

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
None		YES [ ] NO [X]	

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a **I certify** that (I) (this hospital) attended the deceased from 8-24, 1968, to Sept 2, 1968, that (I) (we) last saw the deceased alive on Sept 1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE	DEGREE	22c. DATE SIGNED
Carlton Brinsfield MD	ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]	Sept 3 1968

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. C. BRINSFIELD	401 DECATUR STREET, CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept 5/68	Sunset Memo. Pk.	Cumberland Allegany MD

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Louis Stein Inc.	Cumb. Md	SEP 5 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV

1254X

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12351

Item#13c,e, FilmG405 10/18/68 RM

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
CHARLES	W.	LANGLEY	SEPTEMBER 20, 1968	10:50 P.M.

3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	4-15-1912	56 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
Maryland	U. S. A.	NEVER MARRIED [X]	ALLEGANY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND Frostburg	YES [X] NO [ ]	59 McCulloh St.

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
HOWARD	F.	LANGLEY	ISABELLE		KERR

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT Address
no			MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) SHOCK

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 621

DUE TO, OR AS A CONSEQUENCE OF (b) PERITONITIS DUE to Diverticulitis

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 days

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Right hemiparesis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
None	—	YES [ ] NO [X]	—

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a I certify that (I) (~~this hospital~~) attended the deceased from 9-18, 1968, to 9-20, 1968, that (I) (we) last saw the deceased alive on 9-20 1968, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS	22c DATE SIGNED
Andrew Stasko MD		[X]	[ ]	[ ]	9-21-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
ANDREW STASKO DR. ~~CARLTON XXXXXXXX~~	401 DECATUR ST., CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town)	(County)	(State)
Burial	9/23/68	Old Coney Cemetery	Lonaconing	A.	Md.

24 FUNERAL DIRECTOR	ADDRESS	25a. RECD. BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	SEP 24 1968	Juliana Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12342 — 123.52

1 DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month	Day	Year	2b HOUR
WOODROW	E.	LA RUE	SEPTEMBER	25	68	8:10A

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
MALE	WHITE	11/15/15	52 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PENNSYLVANIA	UNITED STATES	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY CO., Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND, MD.	SACRED HEART HOSPITAL	SHIPPING CLERK	LEWIS SPRINGFIELD TIRE CO.

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIM ITS?	13e. STREET AND NUMBER
PENNA.	SOMERSET	MEYERSDALE	YES [X] NO [ ]	630 BROADWAY

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
FRANK		LA RUE	ELSIE		PYLE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT Address
YES WWII 1941 TO 1946	193-01-7994	PATIENT'S HOSPITAL CHART

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) RUPTURED ESOPHAGEAL VARICES — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO, OR AS A CONSEQUENCE OF

(b) LAENNEC'S CIRRHOSIS — 4 YRS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

DUODENAL ULCER

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	

21a. ACCIDENT WAS UNDERLYING	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)
[ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	HOUR A.M. P.M. Month Day Year 19	

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State
[ ] / [ ]					

22a. I certify that (I) (~~this hospital~~) attended the deceased from JUNE, 1968, to 25 SEPT, 1968, that (I) (we) last saw the deceased alive on 25 SEPT 1968 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED. DIRECTOR	STAFF PHYS	22c DATE SIGNED
[signature]		[X]	[ ]	[ ]	9-26-68

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
BRADDOCK MEDICAL GROUP I. MICHAEL GLICK, M. D.	912 SETON DRIVE, CUMBERLAND, MD. 21502

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
BURIAL	SEPT 28, 1968	UNION CEMETERY	MEYERSDALE	SOMERSET	PA

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
M R PRICE FUNERAL HOME M R Leckonby	325 MAIN ST MEYERSDALE, PA	SEP 30 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
30M REV. 1/68

1

12343

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12358

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED-NAME (Type or print)	First: CLYDE	Middle: E.	Last: LASHLEY	2a. DATE OF DEATH Month: SEPTEMBER	Day: 4,	Year: 1968	2b HOUR: P.M. 10:15
3 SEX: MALE	4 RACE: WHITE	5 DATE OF BIRTH: 12-25-1898	6. AGE (In years last birthday): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN		
7a BIRTHPLACE (State or foreign country): PENN.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.				
10 CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Clerk	12b KIND OF BUSINESS OR INDUSTRY: Grocery Store				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 11 SOUTH LEE ST.			
14 FATHER'S NAME First: LORENZO	Middle	Last: LASHLEY	15 MOTHER'S MAIDEN NAME First: AMY	Middle	Last: SCHRIVER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a **I certify** that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that (I) (we) last saw the deceased alive on [illegible] 19[illegible], and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ 22c. DATE SIGNED: 9-7-68

22d. PHYSICIAN'S NAME (Type): DR. BLANE SCHINDLER 22e. ADDRESS: 43 GREENE ST., CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Sept.7,1968	Sunset Memorial Park	Cumberland, Allegany, Md.

24 FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
James J. Scarelli, Cumberland, Md.	SEP 10 1968	J. Charles Judge

VR A15 (4) 30M REV 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

12344

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12354

1. DECEASED NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year	2b. HOUR
Calton	R.	Lepley	Sept. 3, 1968	1:40p M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Male	White	Aug. 20, 1910	58 YRS			SEPTEMBER 3, 1968	1:40p M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Pennsylvania	USA		Allegany Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hosp.	Farmer	Agricult

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER
Penna.	Somerset	Hyndman		RD#1

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
Norman Lepley	Hanna Troutman	No	194-16-5640	Mrs. Calton Lepley, Hyndman, PaRD#1

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) PULMONARY EMBOLISM, MASSIVE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

716 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) FRACTURE OF RIGHT ANKLE — 5 DAYS

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

110.1

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR 8:00 P.M. 8-29-68	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)
		Tree fell on leg

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State
	Neighbors Farm	Rt. #1 Hyndman, Bedford, Pennsylvania

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED September 3, 1968

ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 7, 1968	Madley Cemetery	Buffalo Mills, Pa. RD#1

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harvey N. Zeigler	Hyndman, Pa.	SEP 9 1968	J. Charles Judge

VR A15ME (5)
10M REV. 3/68

FOR STATE HEALTH DEPT.

12345

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12355

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED NAME (Type or Print) First: George	Middle: Ray	Last: Light	2a DATE KNOWN OF DEATH ESTIMATED ☒ Month Day Year: Sept. 5, 1968	2b HOUR: 3 PM
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: Nov. 1, 10	6 AGE (in years last birthday) YRS: 57	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN	2c. DATE PRONOUNCED DEAD Month September Day 5, Year 1968	2d HOUR: 3 PM
7a. BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md				
10 CITY OR TOWN OF DEATH: Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital--DOA	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Manager	12b KIND OF BUSINESS OR INDUSTRY: Theatre				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b COUNTY: Allegany	13c CITY OR TOWN: Cumberland	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 705 Avondale Ave.			
14 FATHER'S NAME First: Elmer	Middle	Last: Light	15 MOTHER'S MAIDEN NAME First: Mary	Middle	Last: Twigg		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT: Mrs. Kathleen Light	ADDRESS: Cumberland, Md. - Wife			

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: "

DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Sclerosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: "

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☐ NO ☒
21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No / City or Town / County / State

22a **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: September 5, 1968

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION REMOVAL (Specify): Burial	23b DATE: Sept. 8, 1968	23c NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery	23d LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24 FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a RECD BY REGISTRAR DATE: SEP 10 1968	25b REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15ME (2)
10M REV. 1/68

12346

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12356

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
LENA	G.	LINABURG	SEPTEMBER 5, 1968	12:22PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
FEMALE	WHITE	2-20-05	63 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W. VA.	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY CO. Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	26 W. FIRST STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
HENRY		WHITE	ADA	(RAIN S)	HAINES

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
no		MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Rheumatoid Arthritis	1960
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b)	Myocarditis & Decompensation	4 mos
DUE TO OR AS A CONSEQUENCE OF (c)	Arteriosclerosis	5 yrs

428 X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

427 1

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from June, 1962, to Sept. 5, 1968, that (I) (we) last saw the deceased alive on Sept. 5, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS [X]	MED. DIRECTOR [ ]	STAFF PHYS [ ]	22c. DATE SIGNED
Clyde Durrett					9/6/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. C.E.DURRETT	236 VIRGINIA AVE., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 8, 1968	GREENMOUNT Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli,	Cumberland, Md.	SEP 10 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12347 — 123512

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Minnie	C.	Martin	Sept. 26 1968	5:00 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	Oct. 31, 1882	85 YRS.		

7b. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W. Va.	USA	WIDOWED [X]	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	108 Fourth St.	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES [X] NO [ ]	108 Fourth St.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	O.	Saville	Sallie	Shanholtz	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
no		Daughter Mrs. Rubye Puffinburger, Cumberland, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart failure

DUE TO, OR AS A CONSEQUENCE OF (b) Basic Old Age Advanced

DUE TO, OR AS A CONSEQUENCE OF (c) Arteria Sclerotic C. V. Dis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: First Seen Treated 10-26-53

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS UNDERLYING / CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-26-, 1953, to 9-26-, 1968, that (I) (we) last saw the deceased alive on 8-2-, 1968, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above; (I) ~~(we) (did)~~ (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Wm. L. Williams		[X]	[ ]	[ ]	9-27-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. W. F. Williams, M.D.	122 S. Centre St., Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 29, 1968	Welsy Chapel Cemetery	Points, W. Va.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	OCT 1 1968	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12348 12348

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
WILLIAM	E.	MC CLEARY	SEPTEMBER 22, 1968	10:00 PM

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
MALE	WHITE	09-17-02	66 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
WEST VIRGINIA	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND, MD.	SACRED HEART HOSP.		RAILROAD

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	216 N. CENTRE ST.

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
CHARLES		MC CLEARY	PETERS	LAURA	MC CLEARY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (Unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	705-07-9645	HOSPITAL RECORD, 900 SETON DRIVE, CUMB., MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION — APPROX MATE INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS
1109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
HYPERTROPHY OF PROSTATE, URINARY RETENTION, UREMIA

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
[ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	HOUR A.M. P.M. Month Day Year 19	

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 9-16-55, 19__ to 9-22-68, 19__, that (I) (we) last saw the deceased alive on 9-22, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
R.W. Ballin		[ ]	[ ]	[ ]	9-23-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
R. W. BALLIN, M.D.	62 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/26/68	St. Patricks Cem.	Cumberland Allegany Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Lewis Stein Inc.	Cumb. Md.	OCT 1 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV 68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12349 12359

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1. DECEASED NAME (Type or print)	First: CECIL	Middle: W	Last: MC KENZIE	2a. DATE OF DEATH: Month 9	Day 17	Year 68	2b. HOUR: 8:45A M		
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 10-11-95	6. AGE (In years last birthday): 72 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.				
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.						
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): PAINTER	12b. KIND OF BUSINESS OR INDUSTRY: SELF						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CRESAPTOWN	13d. INSIDE CITY LIM.TS? YES [ ] NO [ ]	13e. STREET AND NUMBER: ****					
14. FATHER'S NAME First: DANIEL	Middle: R	Last: MCKENZIE	15. MOTHER'S MAIDEN NAME First: MARY	Middle: JEANETTE	Last: HILEMAN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: YES	(If yes give war or dates of service): WW I	16b. SOCIAL SECURITY NO.: 214-05-6079	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Mesenteric thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO, OR AS A CONSEQUENCE OF

(b): Fecal impaction — 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Adenocarcinoma of rectum - abdomino-perineal resection

19a. DATE OF OPERATION	19b. CONDITION FOR WH CH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. F YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
May 1968		YES [ ] NO [X]	

21a. ACC DENT WAS UNDERLYING	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
[ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	HOUR A.M. P.M. Month Day Year 19	

21d. INJURY OCCURRED	21e. PLACE OF INJURY (At home, farm, street factory, office building, etc)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
While at work [ ] Not while at work [ ]					

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. D RECTOR	STAFF PHYS.	22c. DATE SIGNED
Thomas F. Lewis	M.D.	[X]	[ ]	[ ]	9/18/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. THOMAS F. LEWIS	CUMBERLAND, MD.

23a. BURIAL, CREMAT ON, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCAT ON (City or Town) (County) (State)
Burial	9/20/1968	Restlawn Memorial Gardens	Near Cumberland Alleg Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John J. Hafer, Jr., 230 Balto Ave. Cumberland Md		SEP 23 1968	J. Charles Judge

1

12350

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12360

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b HOUR
MARY		MORGAN	SEPT.	25	1968	9:10 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	MAY 30, 1882	86 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY Md.

10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tal give street address)	12a. USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
MT. SAVAGE		HOUSEWIFE	

13a USUAL RESIDENCE (Where deceased lived, if institut.on: Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	MT. SAVAGE	YES ☒ NO ☐	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM		HAMMERS	BRIDGET		O'BRIEN

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
		MRS. ROBT. MULLIGAN, MT. SAVAGE, MD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Arteriosclerotic CVD.

4129

DUE TO, OR AS A CONSEQUENCE OF (b) Aging

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 yrs?

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

NONE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☒	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUT NG ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R F D No	City or Town	County	State

22a **I certify** that (I) (this hospital) attended the deceased from JUNE, 19 66, to 9/25, 19 65, that (I) (we) last saw the deceased alive on 9-25 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c DATE SIGNED
Martin Rothstein					9-28-65

22d. PHYSICIAN S NAME (Type)	22e. ADDRESS
MARTIN ROTHSTEIN, M. D.	48 BROADWAY, FROSTBURG, MD. 21532

23a BURIAL, CREMAT ON, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	SEPT. 28 '68	HILLCREST BURIAL PARK	CUMBERLAND, MD.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	SEP 30 1968	J. Charles Judge

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12351

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12361

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Item 24) Please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JAMES	R.	MOWRY	SEPT. 13, 1968	9:15PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
MALE	WHITE	12-20-88	79 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PA.	U.S.A.	NEVER MARRIED [X]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Farming	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
PA.	Bedford	HYNDMAN	YES [X] NO [ ]	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JACOB		MOWRY	MIRIAH		SHERMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
		MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Moderate C.V.A. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. — ?

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

None

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 9/4/, 1968, to 9/13/1968, that (I) (we) last saw the deceased alive on 9/13/, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c. DATE SIGNED
W. Himmler		9/12/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. W. HIMMLER	412 N. MECHANIC ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Sept. 17, 1968	Dry Ridge	Manns Choice, Bedford Co.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harvey H. Zeigler, Hyndman, Pa.	SEP 19 1968	Pa. RD Charles Judge

VR A15 (4) 30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12352

CERTIFICATE OF DEATH

12362

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
SARAH	E.	MURPHY	SEPTEMBER 5, 1968	1:25 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	3-28-1888	80 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PENNA.	U.S.A.	WIDOWED X	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
PENNA.		MEYERSDALE	YES / NO	309 NORTH STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
LEWIS		STEINLEY	HUZANNA		HOUSEL

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
		MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral embolism — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 20 hrs

4129

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) ASHD, EKG MI

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cerebral arteriosclerosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING / CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 7-30, 1968, to 9-5, 1968, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Vaiden P. Dross	ATTENDING PHYS. X / MED. DIRECTOR / STAFF PHYS.	9-5-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. V. DROSS	456 N. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
	9-8-68	Greenville Cem.	R.D. #1 Salisbury Pa

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H. P. Konkus	Meyersdale	SEP 10 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

12353

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12363

1 DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH ☒ ESTIMATED ☐ Month Day Year	2b HOUR
Berman	C.	Norris	Sept. 15 '68	6 a.m.

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	White	March 16, 1895	73 YRS			September 15, 1968	6 a.m.

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
Maryland	USA		Allegany Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	Retired Pipe Pickler-Steel	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Pa.		Aliquippa	YES ☒ NO ☐	1104 Wade St.

14 FATHER'S NAME First Middle Lost	15 MOTHER'S MAIDEN NAME First Middle Lost
Isaac W. Norris	Catherine Connars

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
no			Mr. Alfred Padgett, Aliquippa, Pa.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

4201

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: September 15, 1968

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Sept. 18, 1968	Woodlawn Cemetery	Aliquippa, Pa.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
James P. Scarpelli, Cumberland, Md.	SEP 17 1968	J. Charles Judge

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items#5&6 Film/Roll 4 1/23/[illegible] Vital

CERTIFICATE OF DEATH

12364

1. DECEASED'S NAME (Type or print): First JAMES; Middle A.; Last O'HAVER
2a. DATE OF DEATH: Month 09 Day 13 Year 68
2b. HOUR: 9 A M
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: 03-17-88 92
6. AGE (In years last birthday): 79 YRS
If under 1 year: Months; Days
If under 24 hrs: Hours; Min
7a. BIRTHPLACE (State or foreign country): GARRETT CO.
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY CO. Md
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSP.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED
12b. KIND OF BUSINESS OR INDUSTRY: RETIRED
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: RAWLINGS
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: RT. 3
14. FATHER'S NAME First JOHN; Middle; Last O'HAVER
15. MOTHER'S MAIDEN NAME First MARY; Middle; Last DARR
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes YES or unknown (If yes give war or dates of service)
16b. SOCIAL SECURITY NO. 705-05-9370
17. INFORMANT: HOSP. RECORD Address: SACRED HEART., SETON DR., CITY

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): arteriosclerosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years
4401
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 9-4, 19 68, to 9-13, 19 68, that (I) (we) last saw the deceased alive on 9-13- 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: L. Brings MD — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 9-14-68
22d. PHYSICIAN'S NAME (Type): DR. L. BRINGS
22e. ADDRESS: 57 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9/16/68
23c. NAME OF CEMETERY OR CREMATORY: Gaster
23d. LOCATION (City or Town) (County) (State): Rt. 1 Swanton-Garrett-Md.
24. FUNERAL DIRECTOR: BOAL'S FUMERAL HOME
ADDRESS: 111 CHURCH ST., WESTERNPORT MD.
25a. REC'D BY REGISTRAR DATE: SEP 18 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

Ed Boal

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 48 hours after death.

VR A16 (4)
30M REV. 1/68

12353

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12365

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

1. DECEASED-NAME (Type or Print)	First: Ida	Middle: Mae	Last: Platter	2a DATE OF DEATH KNOWN [X] ESTIMATED [ ]	Month: 9	Day: 18	Year: 19 68	2b HOUR: 11:20 A.M.
3. SEX: F	4. RACE: W	5. DATE OF BIRTH: 7/15/1934	6. AGE (In years last birthday): 34 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	2c. DATE PRONOUNCED DEAD: Month: September	Day	Year: 1968	2d. HOUR: 11:20 A.M.
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md						
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital-DOA (?)	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired): Housewife	12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Garrett	13c. CITY OR TOWN: Grantsville	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER					
14. FATHER'S NAME: First: George	Middle	Last: Mason	15. MOTHER'S MAIDEN NAME: First: Anna	Middle: Mae	Last: Rizer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 212-46-2264	17. INFORMANT: Calvin R. Wilt	ADDRESS: Grantsville, Md.					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Shock	Hours
DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Exanguination	M
DUE TO, OR AS A CONSEQUENCE OF		
(c)	Pregnancy (Placenta Praevia)	Full Term

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
6766

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [ ]
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Benedict Skitarelic MD / BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]
ADDRESS (Street, city, town or county): CUMBERLAND, MARYLAND

22b. DATE SIGNED: SEPTEMBER 18, 1968

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 9/21/68	23c. NAME OF CEMETERY OR CREMATORY: Mt. Zion Cemetery	23d. LOCATION (City or Town) (County) (State): Star Rt. Frostburg, Allegany Md.	
24. FUNERAL DIRECTOR: Enoch K. Neuman	ADDRESS: Grantsville, Md.	25a. REC'D BY REGISTRAR DATE: SEP 20 1968	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A1SME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12356 3666

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
D.	KATHLEEN	POLAND	9 4 68	12:08 P M

3. SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	10-19-21	46 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
W. VA.	U.S.A.		ALLEGANY Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Homemaker	Home

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER
W. VA.		KEYSER		RT. 4, BOX 105

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
HAROLD	R.	HARRISON	DELIA	P	ROBERTS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT	Address
No	236 20 9025	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) metastatic Ca of lung c hydrothorax — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mo.

DUE TO, OR AS A CONSEQUENCE OF (b) Ca - Rt breast — 1 yr.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 174X

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

110X

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME FARM, STREET FACTORY OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No. City or Town County State

22a I **certify** that (I) (this hospital) attended the deceased from 13 Aug, 19 68 to 4 Sept, 19 68, that (I) (we) last saw the deceased alive on 4 Sept 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death

22b SIGNATURE	DEGREE: ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐	22c DATE SIGNED
[signature]		7 Sept 1968

22d PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. A. J. MIRKIN	CUMBERLAND, MD.

23a BURIAL CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	7 Sept 68	Laurel Hill	Moscow Allegany Md.

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Allen M. Rotruck	Keyser, W. Va.	SEP 16 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
30M REV 3-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12357

CERTIFICATE OF DEATH

12367

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
LILLIAN		PRESSMAN	SEPT. 28 1968	M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	MAY 8, 1891	77 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U.S.A.	NEVER MARRIED X	ALLEGANY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
FROSTBURG	18 N. GRANT STREET	RETIRED CLERK	DEPT. STORE

13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES X NO	18 N. GRANT STREET

14 FATHER'S NAME First Middle Last	15 MOTHER'S MAIDEN NAME First Middle Last
HENRY PRESSMAN	MARGARET FARRELL

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
	212-01-7469	ROBT. PRESSMAN, FROSTBURG, MD. 21532

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute CVA	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4079 337X	DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arteriosclerosis	Intermittent
	DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic ASHD

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES NO X	

21a ACCIDENT WAS UNDERLYING	21b TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
OR CONTRIB. TING CAUSE OF DEATH (If either, notify medical examiner)	HOUR A.M. P.M. Month Day Year 19	

21d. INJURY OCCURRED While at work / Not while at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a I **certify** that (I) (this hospital) attended the deceased from January 1, 19 68, to Sept. 28, 19 68, that (I) (we) last saw the deceased alive on Sept. 23 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
G. Paige Strong	ATTENDING PHYS. X MED. DIRECTOR STAFF PHYS.	9/30/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
A. PAIGE STRONG, M. D.	167 E. MAIN ST., FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	OCT. 2, 1968	ST. MICHAELS CEMETERY	FROSTBURG, MD.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH. R. DURST, FROSTBURG, MD. 21532	OCT 3 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (U)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12358

CERTIFICATE OF DEATH

12368

1 DECEASED-NAME (Type or print)	First: Merle	Middle: Harvey	Last: Reckley	2a. DATE OF DEATH Month: Sept Day: 23, Year: 1968	2b. HOUR: M	
3 SEX: Male	4 RACE: White	5. DATE OF BIRTH: Sept 10, 1900	6 AGE (In years last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a BIRTHPLACE (State or foreign country): Town Creek Md	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md			
10 CITY OR TOWN OF DEATH: Cumberland.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): DOA Memorial Hosp	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Retired Carpenter	12b KIND OF BUSINESS OR INDUSTRY: Self.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b COUNTY: Allegany	13c CITY OR TOWN: Town Creek	13d INSIDE CITY LIMITS? YES ☐ NO ☑	13e STREET AND NUMBER: Rt #4 Brice Hollow Rd		
14. FATHER'S NAME First: Harvey	Middle: W.	Last: Reckley	15. MOTHER'S MAIDEN NAME First: Sarah	Middle:	Last: House	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT: Mrs. M.H. Reckley	Address: Rt #4 Brice Hollow Rd			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days
DUE TO, OR AS A CONSEQUENCE OF
(b): Coronary atery disease — Aug 68.
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Brochogenic Carcinoma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town / County / State

22a. I certify that (I) (this hospital) attended the deceased from 4-9-, 1968, to 9-23-, 1968, that (I) (~~we~~) last saw the deceased alive on 9-24- 1968, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~and~~) (did not) view the body after death

22b SIGNATURE: Wm. F. Williams DEGREE — ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22c DATE SIGNED: 9-24-68

22d PHYSICIAN'S NAME (Type): William F. Williams, M. D. — 22e ADDRESS: 122 S. Centre St., Cumberland, Md. 21502

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	9/25/68	Mt Jabor Cem.	[redacted] Cumberland Allegany Md

24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Louis Stein Inc.	Cumb. Md.	OCT 1 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (B)
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12359 — 12369

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print) First	ROLAND	Middle B.	Last REDMOND	2a. DATE OF DEATH Month SEPTEMBER Day 2, Year 1968	2b HOUR 2:30 A M
3 SEX	MALE	4 RACE	COLORED	5 DATE OF BIRTH	MAY 11, 1898
6 AGE (In years last birthday)	70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a BIRTHPLACE (State or foreign country)	PENNA.	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH ALLEGANY Md.
10 CITY OR TOWN OF DEATH	CUMBERLAND, MD.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	MEMORIAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Retired Baggage Porter
12b KIND OF BUSINESS OR INDUSTRY	B & O R R				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	MARYLAND	13b. COUNTY	ALLEGANY	13c. CITY OR TOWN	CUMBERLAND
13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER	426 PINE AVENUE.			
14. FATHER'S NAME First	SAUL	Middle	Last REDMOND	15. MOTHER'S MAIDEN NAME First	NETTIE
Middle	Last JONES				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	No	(If yes give war or dates of service)		16b SOCIAL SECURITY NO.	705-05-4482
17. INFORMANT Address	MEMORIAL HOSPITAL, CUMBERLAND, MD.				

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO, OR AS A CONSEQUENCE OF

(b) Generalized Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus Cancerous Prostate

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)

21f LOCATION Street or R.F.D. No. City or Town County State

22a **I certify** that (I) (this hospital) attended the deceased from 8-18, 1968, to 9-2-68, 19____, that (I) (we) last saw the deceased alive on 9-2 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b. SIGNATURE William P. James DEGREE — ATTENDING PHYS [ ] MED. DIRECTOR [ ] STAFF PHYS [ ] — 22c. DATE SIGNED 9/5/68

22d PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES — 22e ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b DATE	9/5/1968	23c NAME OF CEMETERY OR CREMATORY: Sumner Cemetery
23d LOCATION (City or Town)	Cumberland	(County)	Alleg	(State) Md
24 FUNERAL DIRECTOR ADDRESS	Charles E. Hafer 230 Balto Ave. Cumberland	25a RECD BY REGISTRAR DATE	SEP 9 1968	25b REGISTRAR'S SIGNATURE: Charles Judge

Charles E. Hafer

VR A15 M 30M REV. 1-68

1

FOR STATE HEALTH DEPT.

12360

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12370

1 DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH / ESTIMATED	Month Day Year	2b HOUR
Rose	Ella	Ross	ESTIMATED	9-21-68	3:00 P M

3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Female	White	Feb. 17, 1885	83 YRS.			Sept. 21, 1968	3:00 P M

7a. BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W.Va.	U.S.A.	WIDOWED [X]	Allegany Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Westernport	Kolbergs Hill	H.W.	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	Allegany	Westernport	YES [X] NO [ ]	Kolbergs Hill

14 FATHER'S NAME First Middle Last	15 MOTHER'S MAIDEN NAME First Middle Last
George H. Dunk	Annie E. Schramm

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		220-34-1501A	Pearl Kazlo	Westernport, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Osteal Occlusion, right	Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b)	Thrombosis	H
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerosis	

.109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [X] NO [ ]

21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e PLACE OF INJURY (At home, farm, street factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a I certify that I took charge of the remains described above, held an Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b DATE SIGNED: September 21, 1968

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	9/24/68	Philos	Westernport, Allo. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
	Westernport, Md.	SEP 25 1968	Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay s necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12361 12321

1. DECEASED-NAME (Type or print) First: GEORGE	Middle: W	Last: RUMMER	2a DATE OF DEATH Month: SEPT. Day: 24 Year: 1968	2b HOUR A.M P.M: 2:00	
3 SEX: MALE	4 RACE: WHITE	5 DATE OF BIRTH: 1-22-08 1909	6. AGE (In years last birthday): 59 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a BIRTHPLACE (State or foreign country): CUMB. MD.	7b. CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.		
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Score Room Helper	12b KIND OF BUSINESS OR INDUSTRY: B & O R. R		
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: MD.	13b COUNTY: ALLEGANY	13c CITY OR TOWN: CUMBERLAND	13d INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: ROUTE 1, VALLEY ROAD	
14 FATHER'S NAME First: GEORGE	Middle	Last: RUMMER	15. MOTHER'S MAIDEN NAME First: CLARA	Middle	Last: TWIGG
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD. (Address)			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: several m

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Occlusion — 2 days

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

5211

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from [illegible], 19[illegible], to 9/27, 1968, that (I) (we) last saw the deceased alive on [illegible] 19[illegible] and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 9/27/68	
22d. PHYSICIAN'S NAME (Type): DR. BLANE M. SCHINDLER	22e. ADDRESS: 43 GREENE ST., CUMBERLAND, MD.	

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: Sept. 26, 1968	23c NAME OF CEMETERY OR CREMATORY: Davis Memorial Cem.	23d LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: SEP 27 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12362

Item#5, FilmGL04 9/19/68 km

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ALBERT	L.	SCHADE	SEPTEMBER 10, 1968	P.M. 6:20

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
MALE	WHITE	9-27-97	70 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
MARYLAND	U. S. A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Retired Owner of Radiator Service	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	510 MARSHALL ST.

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
NICHOLAS		SCHADE	ELIZABETH		DIABOLD

16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT Address
No	212-32-8349	MEMORIAL HOSPITAL, CUMB. MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1 DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Coronary Thrombosis — short time

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Coronary Artery Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4 3 0 1

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 9-5-, 1968, to 9-10-1968, that (I) (~~we~~) last saw the deceased alive on 9-10-1968 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above. (I) (~~we~~) (did) (~~did not~~) view the body after death

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS	22c DATE SIGNED
Wm. F. Williams		[X]	[ ]	[ ]	9-11-68

22d PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. W. F. WMS.	CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	9-13-68	St. Luke's Cemetery	Cumberland, Allegany, Maryland

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
H. Lee Silcox 404 Decatur St., Cumb., Md.	SEP 16 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR 415-A
30M REV 7-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12363

CERTIFICATE OF DEATH

12373

1. DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
STELLA	P	SHAFFER	9 10 68	12:35 M

3. SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
FEMALE	WHITE	2-4-84	84 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
PENNA.	U.S.A.		ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
PA.	Bedford	HYNDMAN	YES ☒ NO ☐	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
BENJAMIN		BRADIGAN	SARAH		EVANS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	Address
No	216-22-6321	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c))

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Lobar pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary emphysema, advanced — 10 yrs

DUE TO, OR AS A CONSEQUENCE OF (c) Malnutrition — 6 months

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

5221 Cirrhosis of liver

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 8-31, 1968, to 9-10, 1968, that (I) (we) last saw the deceased alive on 9-10 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c DATE SIGNED
V. P. Dross	MD				

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. V. DROSS	CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Sept. 13, 1968	Hyndman Cemetery	Hyndman, Bedford Co., Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Harvey H. Zeigler,	Hyndman, Pa.	SEP 16 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12361 — 12371

1 DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED	Month	Day	Year	2b HOUR
Banner	NMI	Shipley	☒	Sept.	5,	1968,	12:30 PM

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN	2c. DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	White	12/28/1914	53 YRS					SEPTEMBER 5, 1968	12:30 PM

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
Pennsylvania	U S A		Allegany Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital	Forman	Dept of Forest & Parks

13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Maryland	Allegany	Cumberland	YES ☒ NO ☐	1216 Lafayette Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Joseph	O.	Shipley	Clara	NMI	Shaffer

16a WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT	ADDRESS
NO		217-10-4385	Mrs. John J. Harvey	503 Williams St Cumberlan Md.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) MACERATION OF BRAIN — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 26 Hours

DUE TO, OR AS A CONSEQUENCE OF

(b) Fracture of Skull

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 9 6X

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

710.8

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☒ NO ☐

21a EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M.	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
	10:00 AM Sept. 4 19 68	Hit by falling tree

21d INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R F D No	City or Town	County	State
	State Forest	Green Ridge,	Allegany,	Maryland	

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M D

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: September 5, 1968

ADDRESS (Street, city, town, or co) CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	9/ 8/ 1968	Hillcrest Burial Park	Near Cumberland Alleg Md.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Charles E. Hafer, 230 Balto Ave. Cumberland Md	SEP 9 1968	J Charles Judge

VR AT5ME (5) 10M REV 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A-10-1
30M REV 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12365

CERTIFICATE OF DEATH

12375

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Earl		Smith	9 14 1968	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	1/15/1896	72 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Lonaconing	St. Marys Terrace	Retired	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md	Allegany	Lonaconing	YES [ ] NO [X]	St. Marys Terrace

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William		Smith	Elizabeth		Stafford

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
yes 1st W.W	214-07-2140	Mrs. Jessie Smith "Wife"	Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: —
DUE TO, OR AS A CONSEQUENCE OF (b) ACVD — Years
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4109

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 60, to Sept. 14 19 68, that (I) (we) last saw the deceased alive on Sept 10 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS [X]	MED DIRECTOR [ ]	STAFF PHYS [ ]	22c. DATE SIGNED
L. R. Miles Jr. M.D.					9-16-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L. R. MILES, JR., M.D.	LONACONING MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	9/17/68	Sunset Memorial Park	Cumberland	A.	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	SEP 17 1968	J. Charles Judge

1

12366

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12376

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Lenora	Ellen	Smith	Sept	20	1968	4.45PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Feb. 22, 1901	67 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Luke	107 Pratt	H.W.	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Luke	YES ☒ NO ☐	107 Pratt

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles	T.	Beckman	Mary	A.	Steiding

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
no		William H. Smith, Sr.	Luke, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a) (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO OR AS A CONSEQUENCE OF (b) ~~[redacted]~~ d.t. w/w/d Atherosclerosis. — 10 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4201 Chronic Bronchitis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19__ to Sept 20, 1968, that (I) (we) last saw the deceased alive on 9-20-68 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
William W. Lesh	MD				9-21-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
William W. Lesh	Westernport, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	9/23/68	Fitzwater	Swanton		Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
E. L. Boal	Westernport, Md.	SEP 24 1968	J. Charles Judge

VR A15 (4-68) 30M REV.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12367

CERTIFICATE OF DEATH

12377

1. DECEASED-NAME (Type or print): First: Thomas; Middle: E.; Last: Smith
2a. DATE OF DEATH: Month: Sept, Day: 13th. Year: 1968
2b. HOUR: M
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: 10/9/1966
6. AGE (In years last birthday): 1 YRS. IF UNDER 1 YEAR: MONTHS, DAYS. IF UNDER 24 HRS: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): MD.
7b. CITIZEN OF WHAT COUNTRY?: USA.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ CHILD
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: Lonaconing
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Jackson ST.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): None
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.
13b. COUNTY: Allegany
13c. CITY OR TOWN: Lonaconing
13d. INSIDE CITY LIMITS? YES X NO ☐
13e. STREET AND NUMBER: Jackson St.
14. FATHER'S NAME: First: John; Middle: E.; Last: Smith
15. MOTHER'S MAIDEN NAME: First: Donna; Middle: ; Last: Shockey
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: None
17. INFORMANT: John E. Smith (Father) Address: Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Myocardial Ischemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: —
DUE TO, OR AS A CONSEQUENCE OF
(b): Cardiomegaly — 6 mos.
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4299 4344

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hydrocephalus, complete blockage

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from ____, 19 66, to Sept. 13, 19 68, that (I) (we) last saw the deceased alive on Sept. 13 19 68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: L.R. Miles JR MD — DEGREE: ATTENDING PHYS X MED DIRECTOR ☐ STAFF PHYS ☐
22c. DATE SIGNED: 9-14-68
22d. PHYSICIAN'S NAME (Type): L.R. MILES, JR., M.D.
22e. ADDRESS: LONACONING, MD. 21539

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 9/15/1968
23c. NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Lonaconing, Md.
24. FUNERAL DIRECTOR: George Eichhorn ADDRESS: Lonaconing, Md.
25a. RECD BY REGISTRAR DATE: SEP 16 1968
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4) 30M REV 1/68

FOR STATE HEALTH DEPT.

12363

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12378

1 DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH / ESTIMATED	Month Day Year	2b HOUR
FREDERICK	S.	SNELSON		9 - 25- 1968	PM 1:40

3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
MALE	WHITE	AUG. 3, 1912	56 YRS			Sept. 25, 1968	PM 1:40

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
MARYLAND	U.S.A.	MARRIED X	ALLEGANY Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp.te give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
FROSTBURG	Miners Hospital-DOA	EXTRUSION DEPT.	CELANESE

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES X NO	26 BRADDOCK

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
JOHN		SNELSON	ANNIE		ROWBOTHAM

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT ADDRESS
	214-07-1379	MRS. SARAH SNELSON, FROSTBURG, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

		APPROX. MAX. INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ASPHYXIATION	MINUTES
DUE TO, OR AS A CONSEQUENCE OF (b)	CARBON MONNOXIDE POISONING	"
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES X NO

21a EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING / CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a I certify that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide X, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) DR. BENEDICT SKITARELIC

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

22b DATE SIGNED September 25, 1968

ADDRESS (Street, city, town, or county) RD9, CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	SEPT. 28 '68	FBG. MEMORIAL PARK	FROSTBURG, MD.

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	SEP 30 1968	J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME [S]
10M REV. 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-5 (4)
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12369

CERTIFICATE OF DEATH

12379

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
CLARENCE	C	STEPHEN	SEPT. 17 1968	12:05

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / M.N
MALE	WHITE	10-15-1888	79 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
GRANTSVILLE, MD.	USA	MARRIED X	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Retired Farmer	Own Farm

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	ACCIDENT	YES / NO X	ROUTE 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
PETER		STEPHEN	ISABELLE		BROADWATER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
No	220-03-7052	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ?
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma prostate gland — 4yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
177X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES X NO	

21a. ACCIDENT WAS UNDERLYING	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	HOUR A.M. P.M. Month Day Year 19	

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 9/5/, 1968, to 9/17/, 1968, that (I) (we) last saw the deceased alive on 9/17/ 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
W. Himmler	ATTENDING PHYS. X / MED DIRECTOR / STAFF PHYS.	

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. WALTER N. HIMMLER	412 N. MECHANIC ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/20/68	Glade Cemetery	Accident, Garrett, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Scott K. Nieman	Grantsville, Md.	SEP 19 1968	Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A (5-67)
30M REV-5-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12370 12380

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b. HOUR
Harry	B.	Ternent	Sept 12 1968	M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Male	White	Oct, 30th 1889	78 YRS				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
MD.	USA		Allegany Md

10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Frostburg	Miners Hospital	Retired Merchant	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER
MD.	Allegany Lonaconing		X	1 Castle Street

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
George		Ternent	Jeanette		Darnley

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT Address
Yes W-W-#1		Sampson Ternent, Lonaconing, Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Myocardial Ischemia — weeks

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary atherosclerosis — years

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis — years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

4129

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4201

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from ____, 1965, to Sept. 12 1968, that (I) (we) last saw the deceased alive on Sept 12 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS ☐	22c. DATE SIGNED
L. R. Miles					9-13-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L. R. MILES, JR. M.D.	LONACONING MD 21539

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	9/15/1968	Oak Hill Cemetery	Lonaconing, Md.

24. FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
George Eichhorn Lonaconing, Md.	SEP 16 1968	Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12371

CERTIFICATE OF DEATH

12386

1. DECEASED-NAME (Type or print)	First: RALPH	Middle: SYLVEST R	Last: UPLINGER	2a. DATE OF DEATH: Month SEPTEMBER Day 7, Year 1968	2b. HOUR: 2:50 A M		
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: DECEMBER 18, 1909	6. AGE (In years last birthday): 58 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): CUMBERLAND, MD.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.				
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Roofer	12b. KIND OF BUSINESS OR INDUSTRY: Self Empo.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 506 SPRINGDALE ST.			
14. FATHER'S NAME First: CURTIS	Middle	Last: UPLINGER	15. MOTHER'S MAIDEN NAME First: JOSEPHINE	Middle	Last: SHEWBRIDGE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MARYLAND			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Carcinoma, Left Lung & Metastases

DUE TO, OR AS A CONSEQUENCE OF

(b):

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on Sept. 5 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Calvin Y. Hadidian	DEGREE: ATTENDING PHYS [ ] MED DIRECTOR [ ] STAFF PHYS [ ]	22c. DATE SIGNED: 9-9-68	
22d. PHYSICIAN'S NAME (Type): DR. CALVIN Y. HADIDIAN	22e. ADDRESS: 203 GREENE STREET, CUMBERLAND, MD.		

23a. BURIAL CREMATION REMOVAL (Specify): Burial	23b. DATE: Sept. 10, 1968	23c. NAME OF CEMETERY OR CREMATORY: Porter Cemetery	23d. LOCATION (City or Town): Hyndman, Pa.	(County) (State)
24. FUNERAL DIRECTOR: James F. Scarpelli, C	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: SEP 13 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

1

12372

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12381

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: JOHN	Middle: O.	Last: WALKER	2a. DATE OF DEATH Month: SEPTEMBER Day: 20 Year: 1968		2b. HOUR: 5:17 P.M.
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 3-12-15	6. AGE (In years last birthday): 53 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life. Do not use retired.): RETIRED TECH.	12b. KIND OF BUSINESS OR INDUSTRY: A.B.L.LAB.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 90 W. COLLEGE AVE.		
14. FATHER'S NAME: First WILLIAM Middle B. Last WALKER	15. MOTHER'S MAIDEN NAME: First EMILY Middle T. Last TAYLOR					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-07-5421	17. INFORMANT: MEMORIAL HOSPITAL, CUMB. MD.	Address		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Terminal congestive Heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Valvular Heart disease, with aortic stenosis

DUE TO, OR AS A CONSEQUENCE OF (c): Mitral insufficiency. Rheumatic — 10 years ?

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Aortic and Mitral Valve Replacement, 1½ years ago

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes.

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. I **certify** that (I) (this hospital) attended the deceased from 1 Sept., 1966, to 20 Sept., 1968, that (I) ~~(we)~~ last saw the deceased alive on 20 Sept. 1968, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) (~~did not~~) view the body after death.

22b. SIGNATURE: W. A. VanOrmer, M.D.	DEGREE: ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 21 Sept. 68	
22d. PHYSICIAN'S NAME (Type): DR. W. A. VANORMER	22e. ADDRESS: 122 S. CENTRE ST., CUMB. MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 9-23-68	23c. NAME OF CEMETERY OR CREMATORY: F'BG. MEMORIAL PARK,	23d. LOCATION (City or Town): FROSTBURG,	(County): ALLEGANY. (State): MD.
24. FUNERAL DIRECTOR: JOSEPH R. DURST,	ADDRESS: FROSTBURG, MD.	25a. REC'D BY REGISTRAR DATE: SEP 25 1968	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15 (1)
30M REV. 1-68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 6-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12373 — 12382

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
Minnie		Wamsley	at 10:05 AM September 20, 1968	A.M

3. SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	4/19/1870	98 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
West Virginia	U. S. A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	Allegany County. Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	Allegany County Infirmary	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES [X] NO [ ]	101 Mary Street

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Marshall		Mullins	Elizabeth		Golden

16a WAS DECEASED EVER IN U.S ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT
NO		220-52-9938	P.O.Box 599, Cumberland, Md. Allegany County Infirmary records.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Acute Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: a few minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — 4100

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis with hypertension — many years

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis — many years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

T.U.

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a I certify that (I) (this hospital) attended the deceased from Sept 6, 1968, to Sept 20, 1968, that (I) (we) last saw the deceased alive on Sept 20, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS	22c DATE SIGNED
John A Topper	MD	[X]	[X]	[X]	Sept 20, 1968

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John A Topper MD	Memorial Hospital, Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	SEPT. 23, 1968	ZION MEMORIAL PARK	CUMBERLAND, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	SEP 27 1968	J Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12374 12383

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
GILBERT	H.	WARNICK	SEPTEMBER 8, 1968	3:35 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	9-24-1910	57 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Electrician	Paper Mill

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	RAWLINGS	YES [ ] NO [ ]	RT.#3, BOX 68

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
CALVIN	J.	WARNICK	ROSA		PAUGH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)	(If yes give war or dates of service)	16b. SOC. SEC. NO	17. INFORMANT	Address
no		217-07-6563	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of Right Lung - Metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DUE TO OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

153 X

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 9-8 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE: ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Calvin Y. Hedrick, M.D.	[ ]	[ ]	[ ]	9-9-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. F. B. WHITWORTH	305 WASHINGTON ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/12/68	Barnard.	Swanton Garrett Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
E. L. Bral	Westernport, Md.	SEP 16 1968	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S-14
30M REV-68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15ME (5)
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12375

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12389

1. DECEASED NAME (Type or Print) First	Middle	Last
JANE	M.	WIANT

2a. DATE OF DEATH: KNOWN ☒ ESTIMATED ☐ Month 9/16/ Day Year 68 — 2b. HOUR 8 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS: HOURS	MIN
Female	White	Nov. 12. 1886	81 YRS				

2c. DATE PRONOUNCED DEAD Month Sept Day 16 Year 1968 — 2d. HOUR 8P M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	USA		ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	DOA MEMORIAL HOSPITAL	HOUSEWIFE	OWN HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☐ NO ☒	ROUTE 3, VALLEY ROAD

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
JOHN WILKINSON	JOSEPHINE MARTIN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT ADDRESS
NO	UNKNOWN	JAMES A. WIANT, FAIRLESS HILLS, PA.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIOSCLEROSIS — - - - -

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

4201

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED 9/16/68

ADDRESS (Street, city, state) RT. 3, CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	SEPT. 19, 1968	HILLCREST BURIAL PARK	CUMBERLAND, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	SEP 20 1968	J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (A)
30M REV 1/68

1237?
Item#5,6, FirGL05 10/7/68 km

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

12387

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Walter	Lundy	Wigfield	Sept.	19	1968	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	Oct. 2. 1887	86 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH
Flintstone	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Kinch Nursing Home	Paperhanger	Hanging paper

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES ☑ NO ☐	606 Maryland Ave.,

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Johnaton		Wigfield	Deborah C		Shryhoff

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
no		Mrs. Minnie Smith	Cumberland, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uraemia	6 wks
DUE TO, OR AS A CONSEQUENCE OF (b)	Myocarditis	1 yr
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerosis	10 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from Aug 20, 1968 to Sept 19, 1968, that (I) (we) last saw the deceased alive on Sept. 16 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Clay F. Barnett			☒	☐	9/20/68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	9/23/68	Mt Olivet Cem.	Rural Cumberland	Allegany	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Louis Stein, Inc.	Cumberland, Md	OCT 1 1968	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12376 12385

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Joseph		Wiland	9/7/1968	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	2/2/1892	76 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MD.	USA.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Frostburg	Miners Hospital	Retired Carpenter	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER
MD.	Allegany	Lonaconing	X	Robin Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Cyrus		Wiland	Elizabeth		Gray

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
no		John Willand, (SON)	Lonaconing, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial Ischemia

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Insufficiency

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4129 421.0

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Peripheral vascular insufficiency

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from Feb ., 1968, to Sept 7, 1968, that (I) (we) last saw the deceased alive on Sept 7 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
L.R. Miles JR	MD				9-9-68

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L.R. MILES JR	LONACONING MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	9/10/1968	Oak Hill Cemetery	Lonaconing, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn, Lonaconing, Md.	SEP 10 1968	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A154-1
30M REV. 7/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12378

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12388

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form MM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month Day Year	2b. HOUR
DORIS	ANN	WRIGHT	SEPT. 3, 1968	1:a M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
FEMALE	WHITE	4 22 36	32 YRS.			SEPT. 3, 1968	1:a M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
FROSTBURG, MD.	USA		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	HOUSEWIFE	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	FROSTBURG	YES [ ] NO [X]	BOX 106 EDKHART MINES

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
CHARLES F. KERR	MARTHA PHILLIPS KERR

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO. (If yes give war or dates of service)	17. INFORMANT	ADDRESS
NO	220-32-4911	SACRED HEART HOSPITAL	900 SETON DRIVE CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Atelectasis of Lungs, bilateral — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24-48 Hours

450X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Pulmonary emboli — " " "

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

465X Encephalomalacia (Respirator Brain)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED SEPTEMBER 3, 1968

ADDRESS(Street, city, town, or county) CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	9-5-1968	FROSTBURG MEMORIAL	FROSTBURG, ALEG. MD

24. FUNERAL DIRECTOR ADDRESS	26a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Joseph R. Durst, Frostburg MD	SEP 6 1968	Charles Judge

VR A15ME (5)
10M REV. 1/68